Hughes
Federal Credit Union

Benefits Enrollment Guide
January 1, 2018 – December 31, 2018

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INTRODUCTION

In this valuable reference guide, we have included explanations of the benefit programs, important plan information, contact addresses, phone numbers, web addresses and premium charts. This document is a resource to use throughout the year for services and benefits provided to you as a credit union employee. In this guide, you will find information you need to make informed decisions regarding the selection and continued management of your benefits.

How to Use This Guide

The Benefits Enrollment Guide is divided into chapters, each covering a specific benefit program or important information. These programs include:

- Medical Plan
- Dental Plan
- Vision Plan
- Basic, Supplemental and Dependent Life Insurance
- Disability Plans
- Flexible Spending Accounts
- COBRA
- Additional Benefits

It is very important that you review this guide so you can fully understand the benefit programs offered to you through your credit union. Of all the benefits available to you as an eligible employee, these benefits programs may be the most valuable. This is your opportunity to select the coverage appropriate for both you and your qualified dependents.

You must make your initial enrollment selections within 30 days of your date of hire (or eligibility date for newly benefits-eligible employees). If you fail to enroll within the 30-day enrollment period, you waive your right to enroll in these plans until the next Open Enrollment or until you have a Qualified Life Event.

During your initial benefits enrollment, you may take the following actions:

- Elect or decline medical, dental and/or vision plan(s) for yourself and qualified dependents
- Elect or decline supplemental life insurance for yourself
- Elect or decline life insurance for your qualified dependents
- Elect or decline to participate in the Flexible Spending Account (FSA) plans.

ENROLLMENT FACTS

- New employees and newly benefits-eligible employees must enroll within 30 days of the date of hire/benefits eligibility.
- Medical, dental, vision and Flexible Spending Account plans become effective on the first of the month following the date of employment.
- Life, STD, LTD and supplemental life plans become effective on the 91st day following the date of employment.
- 401(k) plans become effective on the first of the month following 90 days of employment.

The Benefits Enrollment Guide is designed to provide an overview of the Benefit Options Program. The actual benefits available to you and the description of these benefits are governed by the relevant summary plan descriptions and contracts. Hughes Federal Credit Union reserves the right to modify, change, revise, amend or terminated these benefit plans at any time.

Contact Information Chart

Contact	Phone Number	Web Address	Policy Number
Medical Plans			
UnitedHealthcare Choice Plus UnitedHealthcare HAS TTY/TDD Pharmacy Services	Customer Care on the back of your ID card or 1-866-633-2446	www.myuhc.com	753179
Dental Plan			
MetLife Dental	1-800-275-4638	www.metlife.com/mybenefits	5550146
Vision Plan			
VSP	1-800-877-7195	www.vsp.com	12159567
Flexible Spending Accounts			
Advantage Group	1-877-506-1660	www.flexasap.com	
Life Insurance Plans			
Cigna	1-800-362-4462	www.mycigna.com	SGM-601643 Life SOK-600961 AD&D
Short and Long Term Disability			
Cigna	1-800-362-4462	www.mycigna.com	SGD-601545 STD SGD-601546 LTD
Travel Assistance			
Cigna	1-888-226-4567	www.mycigna.com	SGD601546 Group #57
401(k) Plan			
John Hancock	1-800-395-1113	www.jhpensions.com	11202
Employee Assistance & Wellness			
Healthy Rewards	1-800-538-3543	www.cignabehavioral.com/CGI www.cigna.com/rewards	User Name=Rewards Password=savings

EMPLOYEE WELLNESS

The benefits package offered by Hughes provides for the fact that you don't check your life at the door when you come to work. Family illnesses, finding care for an aging parent and relationship conflicts are examples of how life can occasionally get out of balance with work.

Employee Assistance programs that are confidential and free are available to help employees sort things out, make changes and get referrals as needed. Worksite wellness programs can help employees reduce their risks for health problems and enhance their well-being.

myuhc.com®

SimplyEngaged® Reward Overview

Take care of your health and be rewarded

SimplyEngaged is a personal health and wellness program which allows you to earn rewards when you complete these health and wellness actions.

It's easy to start earning rewards[1]

Access the Reward Program Overview through Rally™ when you log in to **myuhc.com** for specific details regarding your wellness incentive program.

Earn a Reward

☑ **Participate in a biometric health screening[2] and get a $75 reward**
- Participate in a confidential event through any of the following convenient options: Worksite event (if employer has elected); Health Provider Form; or Lab Screening
- Learn more about your important health numbers: total cholesterol, blood pressure and Body Mass Index (BMI).

☑ **Complete an online health survey[2] through Rally when you log in to myuhc.com® within 90 days of the start of the program and get a $25 reward**
- Answer all of the survey questions to personalize your overall experience.
- Complete the survey and receive your results as a "Rally Age" – an indicator of how your health age compares with your actual age.

☑ **Get a $20 reward each month that you visit a participating fitness center[2] at least 12 times per month**
- Register at a participating fitness center or YMCA® through the Health and Wellness tab on myuhc.com.
- You must present your fitness ID card each time you go to the gym.

☑ **Complete a telephone-based health coaching program and get a $75 reward**
- Complete the health survey in order to participate in this health coaching program.
- Call the Health Coach at 1-800-478-1057 to begin working on your personal health improvement plan.
- Plan accordingly. A telephone-based health coaching session takes three to five months to complete.

☑ **Complete at least 3 Missions[2] through the Rally experience and get a $50 reward**
- Complete the health survey to receive suggested online health actions or "Missions". Missions are interactive and provide choice that may help you maintain your health.
- Plan accordingly. Each mission can take at least four weeks to complete.

☑ **Estimate health care costs on myuhc.com and get a $25 reward**
- Perform at least one cost estimate on an upcoming procedure.
- Get simple, comprehensive estimates for your health care costs to help you make more informed decisions.

UnitedHealthcare®

UnitedHealthcare understands the importance of protecting your privacy.

We care about the relationship we have with you. The services we provide require that we receive personal information and we know it is critical to protect your privacy. Our business practices are in compliance with the privacy requirements under the Health Insurance Portability and Accountability Act (HIPAA), and other applicable privacy and security requirements.

Remember, your health and well-being begins with you.
So take control of your health today and be rewarded.

Please call **1-855-215-0230** if you have questions about your rewards.

UnitedHealthcare®

[1] Type of reward is determined by your employer. Log into myuhc.com and click on the Health and Wellness tab to learn more about the reward applicable to you. There is a maximum associated with these rewards. Employees and covered spouse can earn rewards separately. The worksite event is for employees only. Children may not participate in the reward program. Incentives can be earned only once every plan year.

[2] Log in to myuhc.com with your user name and password. If you are not registered, you can follow the steps under "Register Now". After you are logged into myuhc.com, click on the Health and Wellness tab to access the Rally experience.

If a gift card reward is applicable, the opportunity to select a gift card for completing the required activities under this program will expire within 120 days from the last day of the incentive period. Be sure to select a gift card as soon as you have completed the required activities.

Coins can also be earned under another program, called Rally, for completing certain healthy actions including the ones noted throughout this program.

YMCA is a registered trademark of YMCA of the USA.

Rally Health provides health and well-being information and support as part of your health plan. It does not provide medical advice or other health services, and is not a substitute for your doctor's care. If you have specific health care needs, consult an appropriate health care professional. Participation in the health survey is voluntary. Your responses will be kept confidential in accordance with the law and will only be used to provide health and wellness recommendations or conduct other plan activities.

Coins can also be earned under another program, called Rally, for completing certain healthy actions including the ones noted throughout this program.

SimplyEngaged® is a voluntary program. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical advice. You should consult with an appropriate health care professional to determine what may be right for you. Rewards may be taxable. You should consult with an appropriate tax professional to determine if you have any tax obligations from receiving rewards under this program. If you are unable to meet a standard related to a health factor to obtain a reward under this program, you might qualify for an opportunity to earn the same reward by different means. Contact us at 1-855-215-0230 and we will work with you (and, if necessary, your doctor) to find another way for you to earn the same reward.

All UnitedHealthcare members can access a cost estimator online tool at myuhc.com. Depending on your specific benefit plan and the ZIP code that is entered, either the myHealthcare Cost Estimator or the Treatment Cost Estimator will be available. A mobile version of myHealthcare Cost Estimator is available in the Health4Me mobile app, and additional ZIP codes and procedures will be added soon. This tool is not intended to be a guarantee of your costs or benefits. Your actual costs and/or benefits may vary. When accessing the tool, please refer to the Terms and Conditions of Use and Why Your Costs May Vary sections for further information regarding cost estimates. Refer to your health plan coverage document for information regarding your specific benefits.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates.

Online wellness tools

Online personalized health & wellness homepage – An online welcome page tailored to each individual with health tips, trackers, information, health improvement plans, reminders and articles.

- **Personal health record** – One place to manage personal health care information for the entire family with data integration from medical and pharmacy claims, as well as self-reported information.
- **Online health coach** – Targeted, behavior modification programs to guide you to better health. Reinforces and provides ongoing lifestyle-support for nutrition, exercise, weight management, tobacco cessation, stress management, diabetes and heart health.

Health coaches – experts in the field of health behavior change

The program's health coaches are professionals with degrees and certifications in health related fields such as psychology, nutrition and health education. They help you identify health risk behaviors and suggest tactics and resources to support your health goals. Through collaboration and shared decision-making, the health coach works with you to create a personalized plan that evolves throughout the program.

Health coaches engage you in many ways – integrating telephonic wellness coaching with interactive online tools, trackers and personal messaging.

Accessing the online coaching

Following completion of the Online Health Assessment you can visit **myuhc.com** to access the Online Program.

- Click the "Health and Wellness" button, then select "I Do" and "Add Programs" to get started. Completing a Health Assessment may auto-enroll you in a coaching program, based on your personalized needs.

You can also call the health coach at **1-800-478-1057** to begin working on your personal health improvement plan.

myuhc.com
technical support: **1-877-844-4999**
8 a.m. – 10 p.m. (EST) Monday – Friday

SimplyEngaged® Gift Card Overview

Reward yourself with a gift card from SimplyEngaged®

With the SimplyEngaged program you can log on to myuhc.com to take advantage of our interactive health and wellness activities. These include the online health assessment[3], online health coaching, all designed to help you learn more about your current health and potential health risks for certain diseases and conditions. Once you've finished an activity, you'll be rewarded with a gift card!

Redeeming your health and wellness gift card is easy

After finishing an activity, logon to **myuhc.com**, and select the Health & Wellness tab. Click on *"I Get"*>*"My Rewards"*> *"Redeem Rewards"*. You'll also receive an email notification from **healthyliving@myrewardsredeem.com** after you complete an activity.

It's easy to reward yourself with SimplyEngaged

1 Logon to **myuhc.com**
2 Click on the *"Health & Wellness"* tab,
3 Complete one of the activities[1]

Online Health Assessment[1] on myuhc.com $75

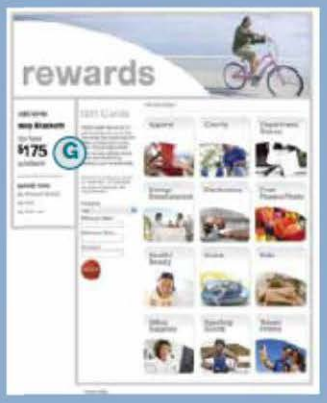
Online wellness coaching program $25

Telephone-based wellness coaching program..... $75

Available for Employees and spouses/ domestic partners covered by this UnitedHealthcare plan

Visit **myuhc.com** to sign up and participate or call **1-877-818-5826** if you have questions about your rewards.

- (A) Earning maximum
- (B) Total dollars earned
- (C) Healthy Activities shows activities available to you
- (D) Reward value for each eligible activity
- (E) Earned rewards per eligible activity
- (F) Redeem Rewards takes you to the page to redeem your rewards
- (G) Current rewards balance available to redeem



Note: If you use your personal email, you may need to add us to your unblocked list so emails aren't viewed as spam. To do so, add healthyliving@myrewardsredeem.com to your contact list. If you use your work email address, your company may need to add our vendor's information to their IT white list so that your reward email isn't blocked as junk mail.

UnitedHealthcare understands the importance of protecting your privacy.

We care about the relationship we have with you. The services we provide require that we receive personal information and we know it is critical to protect your privacy. Our business practices are in compliance with the privacy requirements under the Health Insurance Portability and Accountability Act (HIPAA). Your personal information will not be shared with your employer. Your personal information will be used only by UnitedHealthcare and its wellness program affiliates to provide individualized health information to you to improve your health practices.

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1 Maximum reward per employee $175; Maximum reward per family $350. Each member is eligible to receive a maximum of one reward for completing the wellness activity listed in each category. This includes a maximum of one reward per person for completing the Health Assessment, one for online coaching and one for telephone-based coaching.

Children may not participate in the reward program.

Incentives can be earned only once per plan year. This also pertains to the online and telephonic coaching rewards.

2 Health Assessments can only be completed once every six months. For example, if you complete a Health Assessment today, you will need to wait six months from today to complete another Health Assessment.

3 Members should refer to their health plan ID card and log into the UnitedHealthcare health and wellness website listed on their ID card.

UnitedHealth Wellness® is a collection of programs and services offered to UnitedHealthcare enrollees to help them stay healthy. It is not an insurance product but is offered to existing enrollees of certain products underwritten or provided by UnitedHealthcare Insurance Company or its affiliates to encourage their participation in wellness programs. Health care professional availability for certain services may be dependent on licensure, scope of practice restrictions or other requirements in the state. Some UnitedHealth Wellness programs and services may not be available in all states or for all group sizes. Components subject to change.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates.

UnitedHealthcare Healthy Pregnancy Program

Support. Resources. Healthy Babies and Moms.

That's what you can expect from our Healthy Pregnancy Program. Whether this is your first pregnancy or your third, we can provide you with the information you need to make healthy choices.

Benefits

- No additional cost to you – this is offered as part of your benefit plan
- Pregnancy consultation to identify your risks and special care needs
- Website access for pregnancy and childbirth education materials and resources
- 24-hour* toll-free access to experienced maternity nurses
- Complimentary book: **Mayo Clinic Guide to a Healthy Pregnancy**

Useful information

- Proper nutrition
- Warning signs
- Preparing for childbirth
- Things to avoid
- Exercise during pregnancy

Enroll today

To enroll or to receive additional information call **1-888-246-7389***, toll free.

Care coordinators are available: Monday – Friday 8 a.m. to 8 p.m. CST

For more information visit our website at: **www.healthy-pregnancy.com**

To get the most from the program, it's best to enroll during the first trimester of your pregnancy. But you can enroll whenever you like, up through the end of your pregnancy.

UnitedHealthcare®

* **Please note:** access for questions and concerns is available 24/7, however program enrollment is limited to specific times.

This program follows national practice standards from the Institute for Clinical Systems Improvement. The Healthy Pregnancy Program cannot diagnose problems or recommend specific treatment. The information provided is not a substitute for your doctor's care.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates.

100-5468 5/14 Consumer

Becoming a Dad?

The Healthy Pregnancy program isn't just for moms!

We'll help give you both peace of mind and provide you with resources as you prepare for your new baby.

For many men, becoming a father can be one of the most emotionally intense experiences of their lives.

While a pregnancy brings many changes and challenges – for both the mother- and father-to-be, the experience can also bring you closer together as a family. You may not know how to handle every situation; just being there to listen is one of the best things you can do for your partner. Plus, there are amazing things awaiting you – seeing that first sonogram picture, talking to the baby before he or she is even born, hearing the baby's heartbeat, feeling the baby kick!

Start preparing now to find out what you need to know as you prepare to become a dad. At **www.healthy-pregnancy.com**, you'll find many different articles about what you and your partner can expect before, during and after pregnancy. Plus, your spouse has 24-hour access to experienced nurses all during pregnancy and even after delivery. And, it's all provided at no additional cost for UnitedHealthcare plan members!

Encourage your spouse to enroll in the Healthy Pregnancy Program today.

The Healthy Pregnancy Program helps give both of you extra security and peace of mind, so you can enjoy one of the most beautiful and miraculous experiences in life. Enroll and receive:

- Toll-free, 24-hour access to experienced nurses
- Personalized support to identify risks and individual needs
- Pregnancy and childbirth education materials and resources
- Access to the online Healthy Pregnancy Owner's Manual

For more information, or to enroll

Just call **1-888-246-7389** M–F, 8 a.m. – 8 p.m. Central time

For more information, visit **www.healthy-pregnancy.com**

UnitedHealthcare®

*Please note: Access for questions and concerns is available 24/7; however, program enrollment is limited to specific times.

The Healthy Pregnancy Program follows national practice standards from the Institute for Clinical Systems Improvement. The Healthy Pregnancy Program cannot diagnose problems or recommend specific treatment. The information provided is not a substitute for your doctor's care.

100-15488 1/15 Consumer

Cigna Healthy Rewards®

Looking for more healthy choices? WE'LL HELP.

From acupuncture to natural supplements. Aerobic classes to therapeutic massage. You and your family have health choices like never before. And as part of our ongoing efforts to help people make healthy choices that lead to healthier lifestyles, the Cigna Healthy Rewards* program offers discounts on a wide variety of health programs and services – and it's available at no additional cost if you have a Cigna life, accident, disability, critical illness or accidental injury plan.

Reward yourself

Cigna Healthy Rewards gives you more health care choices and saves you money. There's no time limit or maximum to Healthy Rewards, so you and your covered family members can use them whenever you need them. Enjoy instant savings when you visit a participating provider or shop online.

No referrals. No claim forms. No catch.

You value your health enough to make smart choices. A better, healthier lifestyle is only a click away. Simply visit the Healthy Rewards website to print out a wallet card that you and your covered family members can present to any Healthy Rewards provider to get your discount.

GO YOU™

Cigna.

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Offered by: Connecticut General Life Insurance Company, Life Insurance Company of North America and Cigna Life Insurance Company of New York.

The following Healthy Rewards programs are available to you and your family members.

Weight management and nutrition

Healthyroads™ weight management program

Registered dietitian network

Jenny Craig®

Vision and hearing care

Vision exams, eyewear and contacts

LASIK vision correction

Hearing exams and aids

Tobacco cessation

Healthyroads™ tobacco cessation program

Alternative medicine

Acupuncture

Chiropractic care

Massage therapy

Mind/body

Healthyroads™ mind/body program

Fitness

Fitness club memberships

Just Walk 10,000 Steps-a-Day

Vitamins, health and wellness products

Drugstore.com™

ChooseHealthy.com™

To take advantage of Healthy Rewards savings, go to Cigna.com/rewards (password: savings) or call us at 1.800.258.3312.

Cigna.

* Some Healthy Rewards programs are not available in all states. If your Cigna plan includes coverage for any of these services, this program is in addition to, not instead of, your plan benefits. Healthy Rewards programs are separate from your medical coverage. A discount program is NOT insurance, and the member must pay the entire discounted charge.

WHATEVER LIFE THROWS AT YOU - THROW IT OUR WAY.

Life Assistance Program

Life. Just when you think you've got it figured out, along comes a challenge. Whether your needs are big or small, your Life Assistance & Work/Life Support Program is there for you. It can help you and your family find solutions and restore your peace of mind.

Call us anytime, any day.

We're just a phone call away whenever you need us. At no extra cost to you. An advocate can help you assess your needs and develop a solution. He or she can also direct you to community resources and online tools.

Visit a specialist.

You have three face-to-face sessions with a behavioral counselor available to you - and your household members. Call us to request a referral.

Reward yourself.

Access our Healthy Rewards** discount program. You can get discounts on health and wellness products and services.

Achieve work/life balance.

If you'd like help handling life's demands, call us for extra support. We can refer you to a service in your community. Or provide guidance on topics such as:

Legal consultation.** Receive a free 30-minute consultation. And up to a 25% discount on select fees.

Parenting. Get guidance on child development, sibling rivalry, separation anxiety and much more.

Senior care. Learn how to solve the challenges of caring for an aging loved one.

Child care. Whether you need care all day or just after school, find a place that's right for your family.

Pet care. From grooming to boarding to veterinary services, find what you need to care for your pet.

Financial Services & Referral. Receive a free 30-minute consultation and 25% discount on select fees with network providers.

Life Assistance Program – 24/7 support
800.538.3543
www.cignabehavioral.com/cgi

Together, all the way.™

Cigna.

* Some Healthy Rewards programs are not available in all states. If your Cigna plan includes coverage for any of these services, this program is in addition to, not instead of, your plan benefits. A discount program is NOT insurance, and you must pay the entire discounted charge.

** Legal consultations and discounts are excluded for employment-related issues.

Eligibility

Eligible Employees

Hughes Federal Credit Union employees regularly scheduled to work 30 hours or more per week for six months or longer (except those listed below as ineligible) and their qualified dependents may participate in the Benefit Options and HFCU Benefits Programs and FSA plans, provided they comply with the contractual requirements of their selected plans.

Ineligible Employees

- Employees who work less than 30 hours per week
- Employees in seasonal, temporary or emergency positions
- Students and interns

Eligible Dependents

- Your legal spouse
- Natural, adopted and/or stepchildren unmarried and under age 25 (Dental and Vision) age 26 (Medical Only)
- Minors under the age of 25 (Dental and Vision) age 26 (Medical Only) for whom the employee-member has court-ordered guardianship
- Foster children under the age of 19
- Children placed in the employee's home by court order pending adoption
- Natural, adopted and/or stepchildren who were disabled prior to age 19

Please note: If your dependent child is approaching age 26 (25 for dental and vision) and is disabled, application for such continuation of dependent status must be made within 31 days of the child's 25th or 26th birthday. You will need to provide verification that your dependent child has a qualifying permanent disability, in accordance with Social Security Administration guidelines, that occurred prior to his or her 25th or 26th birthday. Final eligibility will be determined by the Plan Administrator (refer to page 11) and documentation may be required periodically to continue a dependent on your plan.

Dependent Documentation Requirements

If you are enrolling a spouse or dependent whose last name is different from your own, the dependent's coverage will not be processed until supporting documentation, such as a marriage license for a spouse or a birth certificate or court order for dependents, is provided to Human Resources.

Qualified Medical Child Support Order (QMCSO)

If a QMCSO exists, you must elect coverage for your dependent pursuant to the Order. You may not terminate coverage for a dependent covered by a QMCSO.

OTHER IMPORTANT INFORMATION

ID Cards

ID Cards for your medical plan will arrive separately and are sent directly from the vendor to your home address. Typically, ID cards arrive seven to fourteen business days after your benefits become effective.

- MetLife Dental and VSP Vision do not issue ID cards.
- Contact the vendor directly if you do not receive your cards or if you need additional or replacement cards.
- UnitedHealthcare allows members to print temporary ID cards from their website. This may be helpful if you need services before you receive your cards.

Pretax Benefits

When your insurance premiums and contributions to your Flexible Spending Account(s) are made on a pretax basis, your taxable income is reduced. This means you will pay less state, federal, and Social Security (FICA) taxes.

Federal regulations restrict the enrollment status changes that you make during the plan year when your monthly insurance premiums are paid on a pretax basis to the following times:

- Annual Open Enrollment
- Qualified Life Events

The employee benefits that are eligible for pretax premium payments are:

- Medical Insurance
- Dental insurance
- Flexible Spending Accounts (FSAs)
- Health Savings Accounts (HSAs)

After-Tax Benefits

Plans paid for with after-tax premiums do not have the same restrictions during the plan year. You can reduce or cancel after-tax plans without a Qualified Life Event. However, midyear enrollment can only occur in conjunction with an appropriate Qualified Life Event provided the request is made within 31 days of the event.

Examples of plans with after-tax premiums are:

- Voluntary life insurance
- Dependent life insurance

Social Security

Any reduction in your taxable pay for Social Security purposes could lead to a reduction in your future Social Security benefits. Many employees find the reduction in future Social Security benefits insignificant when compared to the value of paying lower taxes today. However, if this is of concern to you, please consult a tax advisor for more information.

CHANGING YOUR BENEFITS

You may only change your benefit elections during the year if you experience a Qualified Life Event. ***Qualifying Life Events include but are not limited to:***

Qualifying Life Event	
MARITAL STATUS CHANGES	***COVERED DEPENDENT CHANGES***
• Marriage • Divorce • Legal Separation • Annulment • Death of Spouse • Spouse gains or loses coverage from another source • Spouse employer's Open Enrollment	• Birth or adoption of a child • Death of dependent child • Dependent becomes ineligible for coverage

Timeframe to Submit a Change Request

Requested benefit changes must be submitted to your Human Resources Office within **31 calendar days** of the event. Failure to request a change **within 31 days** will result in the denial of benefit changes until the next qualified life event or annual Open Enrollment.

Effective Date of the Change

Consult with your Human Resources Office to determine whether or not the life event you are experiencing qualifies under the regulations for the effective date of the change and for the documentation you are required to submit.

MEDICAL PLAN FEATURES

What will be my costs if I obtain services outside the network?

Enrolled in Choice Plus plan:

When members choose to go outside of the network, they will be subject to a deductible for hospital and other applicable services, and a greater percentage of the service provider's cost.

- The member is responsible for any amount above the Allowed Amount and billed charges. This difference will not be applied toward the deductible and/or out-of-pocket maximum.
- The member's total responsibility for out-of-network services includes the deductible, co-insurance, and the difference between the billed charges and the allowed amount.
- You may be asked to pay some or all of the bill before you leave. Also, some doctors not in our network are not able to submit your claim to UnitedHealthcare directly. This means you would have to pay the bill and then submit a medical claim form to UnitedHealthcare.

Enrolled in HSA plan:

When members choose to go outside of the network, they will be subject to a larger deductible for hospital and other applicable services, and a greater percentage of the service provider's cost.

- The member is responsible for any amount above the Allowed Amount and billed charges. This difference will not be applied toward the deductible and/or out-of-pocket maximum.
- The member's total responsibility for out-of-network services includes the deductible, co-insurance, and the difference between the billed charges and the allowed amount.

How do I know if my physician is considered in-network?

First, contact your physician. He/she will know if they are covered with UnitedHealthcare. Also, for the most up-to-date listings of physicians, review the information contained on their website, *www.myuhc.com*. Always check with the physician to ensure they are still contracted with UnitedHealthcare.

How will out-of-network deductibles be tracked?

The deductible amounts will be tracked by UnitedHealthcare and members will obtain notice when they receive their Health Statements for the services provided. Members may also track utilization at *www.myuhc.com*.

Can I obtain services out of the service area?

The UnitedHealthcare plan includes network coverage throughout the United States. UnitedHealthcare providers offer medical treatment. Therefore, you and your dependents may access care outside of your normal service area.

Do I have to choose a primary care physician (PCP)?
No, you are eligible to see any PCP of your choosing. However, remember to visit a participating physician, to maximize your benefit plan with access to lower, out-of-pocket expenses. Selecting a primary Care provider can be helpful in managing your care.

Do I have to have a referral to see a specialist?
No, you are eligible to see a specialist without a referral. You may want to check with your physician for recommendations. Also, some specialists are requiring that patients obtain referrals prior to making an appointment. This is a requirement of the specialist and not a function of your insurance.

What is a deductible?
A specified amount of money a member must pay for hospital care and other applicable services, before insurance benefits begin. The amount listed on the Medical Plans chart is an annual amount, based on the fiscal year (January 1 – December 31). There are individual and family amounts. If you have employee only coverage, the individual deductible applies. If you have family coverage, the deductible is tracked separately for each individual in the family, so benefits begin for the member when the individual deductible has been met - not the family level deductible. For example, one family member is hospitalized and pays the cost of the care to meet the deductible ($500) then the co-insurance applies. If another member of the family is hospitalized, that member must meet his/her own individual deductibles of $500 before the co-insurance applies. The two individuals have now met the family deductible of $1,000. Now that the family deductible has been met, all further similar services will be paid at the appropriate co-insurance amount.

What is the difference between a copayment and co-insurance amount?
A cost sharing arrangement in which a member pays a specified charge for a specific service is a copayment. Co-insurance is the portion paid by the member that is a percentage of the service provider's cost (i.e. 80% paid by plan and 20% paid by member for inpatient hospital charges).

What is Out-of-Pocket Maximum?
These are the costs borne by the member and do include the deductible or copayments. For example, when a member goes out-of-network, the member will pay all charges for services for hospital care and other applicable services until the $1,000 deductible has been met, plus 50% of costs after that. Once the out-of-pocket maximum has been met, i.e., $6,000, the individual does not pay any more. There are individual and family annual amounts.

What is the difference between Emergency Services and Urgent Care?
Emergency Services are those services required as a result of unforeseen injuries or acute illness for which a delay in treatment would result in permanent physical impairment or loss of life. Urgent Care is defined as those services required as a result of unforeseen injuries or acute illness that require immediate attention. UnitedHealthcare asks you to try to contact your Primary Care Physician and arrange care with your PCP if possible.

Will I have a choice of hospitals?
It is always best to verify that the hospital you choose is contracted with UnitedHealthcare, but most of the hospitals in the Tucson and Phoenix area will be available to you as a preferred provider. If you choose a hospital that does not have a contract with UnitedHealthcare, your out-of-pocket expenses will increase.

What about emergency services?
If you are enrolled in the Choice Plus plan, there is a copayment of $300, both in- and out-of-network, for emergency room services. In-network, the copayment will be waived in the event you are admitted to the hospital. If you are enrolled in the HSA plan, the member is subject to deductibles and coinsurance.

What about annual physicals and related tests?
If you are enrolled in the Choice Plus, for annual physicals provided by in-network providers, you will be charged a copayment. In-network providers may cover related tests. If you are enrolled in the HSA plan, the member is subject to deductibles and coinsurance. Annual preventive wellness exams are not subject to deductible/copay and are covered 100%, if services are received from a UHC participating provider.

What is a Plan Administrator?
A Plan Administrator is the contracted organization that processes the medical claims, provides customer service and runs the day-to-day operations of the health plan. The Plan Administrator for Hughes Federal Credit Union is UnitedHealthcare.

Additional Things to Consider
If your doctor orders tests or procedures for you during the year, it will also benefit you to discuss with the doctor the actual costs. Remember, if your doctor or the attending physician is a non-network provider, there will be additional costs to you. Also, when filling a prescription, ask the pharmacy how much the prescription would cost if you had no insurance. As a consumer, you need to ask some questions to keep your out-of-pocket expenses and healthcare premiums from skyrocketing.

UnitedHealthcare
Healing health care. Together.

MEDICAL PLAN SUMMARY CHART

This summary chart highlights many features of the medical insurance plan offered to eligible Hughes Federal Credit Union employees. While every effort has been made to ensure the accuracy of this chart, in the event of any discrepancy, the legal documents, policies, or health benefits contracts pertaining to the various benefits will prevail. ***THIS SUMMARY IS NOT INTENDED TO BE A COMPLETE BENEFIT DESCRIPTION.***

	UNITEDHEALTHCARE CHOICE PLUS	UNITEDHEALTHCARE HSA
Description of Coverage		
Deductible		
In Network	$1,000/$2,000	$3,000/$6,000
Out of Network	$2,000/$4,000	$6,000/$12,000
Coinsurance		
In Network (Plan/EE)	80% - 20%	100% - 0%
Out of Network (Plan/EE)	50% - 50%	50% - 50%
Maximum Out-of-Pocket		
In Network	$4,000/$8,000	$3,000/$6,000
Out of Network	$6,000/$12,000	$6,000/$12,000
Includes Deductible?	Yes	Yes
Office Visits		
In Network (PCP/Specialist)	$25/$50	0% after deductible
Out of Network	50% after deductible	50% after deductible
If you receive services in addition to office visit, additional copays, deductibles, or co-insurance may apply.		
Inpatient Hospitalization		
In Network	20% after deductible	0% after deductible
Out of Network	50% after deductible	50% after deductible
Lab/X-Ray Services (Excludes Specialty Scans)		
In Network	No Charge	0% after deductible
Out of Network	50% after deductible	50% after deductible
Imaging Services (i.e., MRIs, MRAs, PET/SPECT Scans) Physician's Office In Network Freestanding Facility In Network Outpatient Hospital In Network	$250	0% after deductible
Out of Network	50% after deductible	50% after deductible
Emergency Room		
In Network	$300 (waived if admitted to hospital)	0% after deductible
Out of Network	$300	50% after deductible
Urgent Care		
In Network	$75	0% after deductible
Out of Network	50% after deductible	50% after deductible
Prescription Drugs		
In Network	$10/$30/$50	$10/$35/$60 after deductible
Out of Network	Copay + balance (retail only)	Copay + deductible + balance (retail only)

2018 Rates CHOICE PLUS with $1,000 Deductible			
Coverage	*Annual Employee Cost*	*Annual Credit Union Cost*	*Per Pay Period - Employee Cost*
Employee Only	$1,007.50	$4,029.62	$38.75
Employee + Spouse	$2,115.62	$8,462.26	$81.37
Employee + Child(ren)	$2,014.75	$8,059.49	$77.49
Employee + Family	$3,223.74	$12,895.02	$123.99

2018 Rates HSA				
Coverage	*Annual Employee Cost*	*Annual Credit Union Cost*	*Annual Credit Union HSA Contribution*	*Per Pay Period - Employee Cost*
Employee Only	$883.48	$3,533.36	$750.00	$33.98
Employee + Spouse	$1,855.10	$7,420.18	$1,500.00	$71.35
Employee + Child(ren)	$1,766.70	$7,066.86	$1,500.00	$67.95
Employee + Family	$2,826.72	$11,307.12	$1,500.00	$108.72

Coverage Level	Hughes Federal Credit Union's HSA Contribution Amount	Employee's Maximum 2018 HSA Contribution Amount	Total Maximum 2018 HSA Contribution Amount
Employee Only	$750.00	$2,700.00	$3,450.00
Employee & Spouse	$1,500.00	$5,350.00	$6,850.00
Employee & Child(ren)	$1,500.00	$5,350.00	$6,850.00
Family	$1,500.00	$5,350.00	$6,850.00

MEDICAL PLAN CHOICE

Employees have the choice of enrolling in UnitedHealthcare's Choice Plus or High Deductible HDHP (HSA) plan. Please review the information above regarding the different features of each plan. ***To participate in a HSA, you must activate your HSA with Hughes Federal Credit Union in order to receive biweekly contributions and to make your own pre-tax contributions. Please complete the form included in your enrollment materials to participate in the HSA and to have Hughes contribute to your HSA on a per paycheck basis.*** Employee HSA contributions may be changed quarterly up to the maximum permitted by law.

ONLINE FEATURES OF MEDICAL PLAN

Members enrolled in UnitedHealthcare can view the following information on www.myuhc.com. You will need to register with a user name and password:

myuhc.com is an essential resource for members, providing access to all relevant and personal information — whenever they need it

Features include:

- **Intuitive navigation**, featuring the myuhc.com "Launch Pad," providing instant access to frequently used features
- Ability to **find a physician by location** or based on **illness** and ability to **send information to a member's cell phone**
- **myHealthcare Cost Estimator**, providing personalized, comprehensive estimates to help members **understand the costs** of their treatment options
- **myClaims Manager**, provides information to help members better understand their benefits, how their claims were processed and what they owe.

- Improved hospital search, focusing on **cost and quality ratings** and comparisons **at the procedure level**
- Enhanced Personal Health Record, with more content and **customization options**, including ability for members to **authorize online access for their physician**

Slide 1

UHC VIRTUAL VISITS

Virtual Visits

When you work with UnitedHealthcare, you can offer virtual visits to your employees at no additional administrative cost to you. You no longer have to spend time or money assessing, selecting, and implementing an external virtual visit provider. We seamlessly integrate virtual visits into your health plan. The virtual visit provider groups we contract with deliver care using live audio and video technology based on quality standards aligned with American Medical Association (AMA) and Federation of State Medical Boards (FSMB) guidelines.

When employees are sick they often miss work. If they are unable to see their own doctor, they may visit an urgent care or emergency department, which can be costly and time-consuming. With virtual visits, employees can see and speak to a doctor 24 hours a day/7 days a week using a mobile device or computer, all from the convenience of their home or office. If needed, a prescription* can be sent to their local pharmacy. Virtual visits are integrated into their medical benefits.

No administrative costs

Virtual visits are fully integrated with your benefit plan administered by UnitedHealthcare and provided at no additional administrative cost to employers. Members have cost share responsibility and all claims are adjudicated according to the terms of the member's benefit plan.

What sets UnitedHealthcare's option apart from others?

- Member choice and price transparency
- Contracted virtual visit provider groups are aligned with AMA and FSMB guidelines
- Seamless member experience

*Prescription services may not be available in all states. Go to myuhc.com for more information about availability of prescription services.

UnitedHealthcare®

Integrating virtual visits with medical benefits

Virtual visits are covered under member health plans administered by UnitedHealthcare with some member cost share. Member cost share is based on benefits plan set up as follows:

Your benefit plan	The virtual visit benefit for 2016
High-Deductible Health Plan	• Follows standard medical plan rules • Member pays full cost of virtual visit until deductible is met • Virtual visit cost is approximately $40-50 • Once deductible is met, member pays their co-insurance or co-pay under their medical plan rules • Once out-of-pocket maximum is met, member pays $0
Co-insurance and Deductible plans	• Follows standard medical plan rules • Member pays same member cost-share percentage, pre- and post-deductible • Once out-of-pocket maximum is met, member pays $0
Co-pay plans	• Can be set to the same co-pay level as an office visit OR • A lesser co-pay than standard office visit

(Subject to operational limits)

The cost of virtual visits

- Claim cost:
  $40-50 per each virtual visit
- Administrative cost:
  $0
- Member cost:
  - 2015:
    Same cost share as standard office visit
  - 2016:
    Co-pay plans can be at or below in-office visit rate, depending on client preference

The virtual visit provider groups we contract with are aligned with American Medical Association (AMA) and Federation of State Medical Boards (FSMB) guidelines. Contracted provider groups are currently operating in 48 states.*

For more information contact your UnitedHealthcare representative.

UnitedHealthcare®

* Contracted virtual visits provider groups may vary by state and are subject to changes dependent on state laws and regulations.

Virtual visits are not an insurance product, health care provider or a health plan. Virtual visits are an internet-based service provided by contracted UnitedHealthcare providers that allow members to select and interact with independent physicians and other health care providers. It is the member's responsibility to select health care professionals. Care decisions are between the consumer and physician. Virtual visits are not intended to address emergency or life-threatening medical conditions and should not be used in those circumstances. Services may not be available at all times or in all locations. Members have cost share responsibility and all claims are adjudicated according to the terms of the member's benefit plan. Payment for virtual visit services does not cover pharmacy charges; members must pay for prescriptions (if any) separately. No controlled substances may be prescribed. Other prescriptions may be available where clinically appropriate and permitted by law, and can be transmitted to the pharmacy of the member's choice.

Administrative services provided by United HealthCare Services, Inc. or their affiliates.

NETWORK PLAN COVERAGE FOR ROUTINE AND URGENT/EMERGENCY CARE

UnitedHealthcare	
Routine medical care	
Routine medical care means a regular course of treatment that is anticipated, expected and planned for. Routine medical care is usually conducted in the medical provider's office.	
Central and Southern Arizona	Covered
Rural Arizona	Covered
Traveling in United States	Covered
Living Outside of Arizona	Covered
International Travel	Not Covered
Urgent and Emergency Care	
Emergency care means the medical, surgical, hospital and related health care services required to stabilize an injury or serious illness that could result in serious medical complications, loss of life, or permanent physical impairment	
Central and Southern Arizona	Covered
Rural Arizona	Covered
Traveling in United States	Covered
Living Outside of Arizona	Covered
International Travel	Covered

DENTAL PLAN FEATURES

How does the MetLife PDP work?

With a dental benefit plan featuring the MetLife PDP, you receive benefits whether or not you and/or each eligible dependent visits a participating dentist. However, when you visit a participating dentist, you have the opportunity to maximize your benefit plan with access to lower, out-of-pocket expenses. The MetLife PDP is a Preferred Provider Organization (PPO), wherein you choose a provider at the time of treatment. You do not have to pre-select a primary dentist nor do you need an ID card or referrals for specialty care.

What is a participating PDP dentist?

A general dentist or specialist who meets MetLife's strict credentialing standards and accepts negotiated fees as payment-in-full for services rendered.

How do I find a Participating PDP dentist?

You can call the PDP automated Computer Voice Response line to obtain an up-to-date directory of participating dentists in your area. To receive your personalized directory, call 1-800-474-7371 Mon.-Fri. 6:00am to 11:00pm ET or Saturday 7:00am to 4:00pm. You can also conduct online provider searches (with direction and mapping capabilities) via MetLife's Dental Internet site at *www.metlife.com/mybenefits* .
Please Note: Be sure to verify provider participation when you make your appointment.

How do I file a claim?

Claim forms can be downloaded from the Credit Union's Intranet website (under departments and Human Resources) or from MetLife's website at *www.metlife.com/mybenefits* . The same form can be used whether your dentist is a participating dentist or not. MetLife will mail you a concise explanation of benefits (EOB) after each claim submission. If you have a claim inquiry or benefit questions, please call Human Resources or MetLife's Dental Customer Service Department at 1-800-ASK-4-MET after your plan's effective date.

If I do not enroll during my initial enrollment period can I still purchase Dental Insurance at a later date?

Yes, employees who do not elect coverage during their 31 day application period may still elect coverage later. Dental coverage would be subject to the following waiting periods:

- 6 months on Basic Restorative (Fillings)
- 12 months on all other Basic Services
- 24 months on Major Services
- 24 months on Orthodontia Services (if applicable)

Choosing a Dentist

Selecting a dentist who meets your needs and expectations is a decision that's too important to make without investing your time and effort. When you need a dentist, you want a professional you can trust. Don't select a dentist on the basis of cost or advertisements alone.

Though daily brushing and flossing make a difference, seeing a dentist regularly is essential to keeping your teeth, gums and mouth healthy. Through regular visits and cleanings, your dentist can detect and remedy potential problems, offering care that ensures a lifetime of good oral health. If you don't have a dentist, don't wait until a problem forces you to find one.

This **Life Advice**® pamphlet about Choosing a Dentist was produced by the **MetLife Consumer Education Center** and reviewed by the Academy of General Dentistry and the MetLife Dental Advisory Council.

ONLINE FEATURES OF DENTAL PLAN INFORMATION

Members enrolled in MetLife can view the following information on *www.metlife.com/mybenefits* (you will need to register with a user name and password):

Personal Profile	Verify benefits and eligibility.
Provider Search	Find an in-network dentist
Provider Information	You may view the status of your member eligibility and all claims submitted.
Claims Inquiry	View and read the status of all dental claims submitted for payment, including billed charges, any deductibles or co-pays made, the amount paid to the provider, and details on provider payments.
Deductible Status	View all of the co-pays and deductibles paid to date for tax purposes or the amounts accrued towards any plan maximums.
Treatment Cost	Find out and compare what different treatments will cost using the Treatment Cost Estimator, before you need to make a decision.

DENTAL PLAN SUMMARY CHART

This summary chart highlights many features of the dental insurance plan offered to eligible Hughes Federal Credit Union employees. While every effort has been made to ensure the accuracy of this chart, in the event of any discrepancy, the legal documents, policies, or health benefits contracts pertaining to the various benefits will prevail. ***THIS SUMMARY IS NOT INTENDED TO BE A COMPLETE BENEFIT DESCRIPTION*****.**

MetLife Dental Preferred Dental Program		
Plan Design	**In-Network**	**Out-of-Network**
Annual Maximum	$1,000 per person	$1,000 per person
Deductible***	$50 per individual $150 Family Maximum (waived for preventive)	$50 per individual $150 Family Maximum (waived for preventive)
Preventive	100% of PDP Fee*	100% of R&C Fee**
Basic	80% of PDP Fee*	80% of R&C Fee**
Major	50% of PDP Fee*	50% of R&C Fee**
Orthodontia	50% of PDP Fee* Lifetime Max (child only) $1,000 per person	50% of R&C Fee* Lifetime Max (child only) $1,000 per person

*PDP Fee refers to the negotiated PDP fee schedule
**R&C charges are based on the lessor of (a) dentist's usual charge, (b) usual charge for the community, or (c) actual charge
***Applies to Basic and Major services only

- "In-network" means benefits for services that are rendered by a participating PDP provider
- "Out-of-network" means benefits for services that are rendered by a non-participating PDP provider

MetLife Primary Covered Services	
Preventive	Oral Examinations Prophylaxis - Cleaning and Scaling of teeth Space Maintainers (dependents under age 19) Topical Flouride Applications Full mouth and Bitewing X-rays
Basic	Fillings Extractions Anesthesia Injections of Antibiotic Drugs Oral Surgery Emergency palliative treatment
Major	Endodontics - Root Canal Periodontics Repair of crowns, dentures, inlays and onlays Repair of Bridgework Bridgework Crowns, Onlays and Inlays Dentures

2018 Rates			
Coverage	*Annual Employee Cost*	*Annual Credit Union Cost*	*Per Pay Period – Employee Cost*
Employee Only	$87.10	$261.48	$3.35
Employee + Spouse	$168.74	$506.16	$6.49
Employee + Child	$168.74	$506.16	$6.49
Employee + 2 or more	$281.32	$844.32	$10.82

VISION PLAN FEATURES

How does the Vision Service Plan work?

With a vision benefit plan from VSP, you receive benefits whether or not you and/or each eligible dependent visits a participating doctor. However, when you visit a participating doctor, you have the opportunity to maximize your benefit plan with access to lower, out-of-pocket expenses. You choose a provider at the time of treatment. You do not have to pre-select a primary doctor nor do you need an ID card or referrals for specialty care.

How do I find a Participating VSP doctor?

You can call VSP at 1-800-877-7195 to obtain an up-to-date directory of participating doctors in your area. You can also conduct online provider searches (with direction and mapping capabilities) via the VSP Internet site at *www.vsp.com*. *Please Note: Be sure to verify provider participation when you make your appointment.*

How do I file a claim?

Claim forms can be downloaded from the VSP website at *www.vsp.com* . However, if you select a doctor in-network, there is no need to file a claim. The doctor and VSP handle the claim. If you have a claim inquiry or benefit questions, please call Human Resources or contact VSP at 1-800-877-7195 or visit their website at *www.vsp.com* after your plan's effective date.

How do I enroll?

All full-time regular employees and their dependents are automatically enrolled in the vision plan; there are no enrollment forms to complete

ONLINE FEATURES OF VISION PLAN INFORMATION

Members enrolled in VSP can view the following information on *www.vsp.com* (you will need to register with a user name and password):

Personal Profile	Verify benefits and eligibility.
Provider Search	Find a VSP doctor
Provider Information	You may view the status of your member eligibility.

VISION PLAN SUMMARY CHART

Your VSP Vision Benefits

Welcome to VSP® Vision Care. We'll help keep you and your eyes healthy through personalized care from a doctor you can trust.

Your eyes say a lot about you and can even tell your VSP doctor about you. During your WellVision® Exam, your VSP doctor will look for vision problems and signs of health conditions too.

Getting started is a breeze.

- **Find the right VSP doctor for you.** You'll find plenty to choose from at **vsp.com** or by calling **800.877.7195**.
- **Already have a VSP doctor?** Make an appointment today and tell them you're a VSP member.
- **Check out your coverage and savings.** Visit **vsp.com** to see your benefits anytime and check out how much you saved with VSP after your appointment.

That's it! We'll handle the rest—no ID card necessary or claim forms to complete.

Visit the Eyecare Discovery Center at **vsp.com** for eye health articles, videos, and interactive games.

Keep your eyes healthy and your vision clear. Make your appointment today!

Contact VSP | vsp.com 800.877.7195

VSP Vision care for life

HUGHES FEDERAL CREDIT UNION and VSP provide you an affordable eyecare plan.

Doctor Network..... *VSP Signature*

Your Coverage with a VSP Doctor

$20.00 copay every plan year

WellVision Exam® focuses on your eye health and overall wellness..... ***every plan year[1]***

Prescription Glasses

Lenses..... ***every plan year[1]***
- *Single vision, lined bifocal and lined trifocal lenses*
- *Polycarbonate lenses for dependent children*

Frame..... ***every other plan year[1]***
- *$130 allowance for a wide selection of frames*
- *20% off amount over your allowance*

~OR~

Contact Lens Care..... ***every plan year[1]***

$130.00 allowance for contacts and the contact lens exam (fitting and evaluation)
Current soft contact lens wearers may qualify for a special program that includes a contact lens exam and initial supply of lenses.

Extra Discounts and Savings

Glasses and Sunglasses
- *Average 35 - 40% savings on all non-covered lens options*
- *30% off additional glasses and sunglasses, including lens options, from the same VSP doctor on the same day as your WellVision Exam. Or get 20% off from any VSP doctor within 12 months of your last WellVision Exam*

Contacts
- *15% off cost of contact lens exam (fitting and evaluation)*

Laser Vision Correction
- *Average 15% off the regular price or 5% off the promotional price. Discounts only available from contracted facilities.*
- *After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor.*

Your Coverage with Other Providers

Visit vsp.com for details, if you plan to see a provider other than a VSP doctor.

Exam	*Up to $ 50.00*
Single Vision Lenses	*Up to $ 50.00*
Lined Bifocal Lenses	*Up to $ 75.00*
Lined Trifocal Lenses	*Up to $ 100.00*
Frame	*Up to $ 70.00*
Contacts	*Up to $ 105.00*

VSP guarantees service from VSP doctors only. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail.

[1] *Plan year begins in January*

Member:

vsp

Coverage Type:
Client ID:
Doctor Network:
Copays:

For more about your coverage
visit vsp.com, or call 800.877.7195.

xx/xx/xxxx

Using your VSP® benefit is easy.

- Find the eyecare provider who's right for you.
  To find a VSP doctor, visit **vsp.com** or call **800.877.7195**.
- Review your benefit information at vsp.com before your appointment.
- At your appointment, tell them you have VSP.

My Eyecare Provider:_____
Phone:_____

This card is not required for service and does not guarantee benefit eligibility. It is for use by VSP members. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail.
Utah members, your VSP coverage is provided by Vision Service Insurance Plan Company and is regulated by the State of Utah Insurance Division.

2018 Rates			
Coverage	*Annual Employee Cost*	*Annual Credit Union Cost*	*Per Pay Period – Employee Cost*
Employee Only	$0.00	$108.84	$0.00
Employee + Spouse	$0.00	$157.92	$0.00
Employee + Child	$0.00	$157.92	$0.00
Employee + 2 or more	$0.00	$283.08	$0.00

ARIZONA, NATIONAL AND INTERNATIONAL COVERAGE (MEDICAL, DENTAL AND VISION)

	Within Arizona	Within U.S.	International
Medical			
UnitedHealthcare	Covered in/out-network	Covered with UnitedHealthcare Provider	Covered out-of-network
Dental			
MetLife Dental	Covered in/out-network	Covered in/out-network	Covered out-of-network
Vision			
VSP	Covered in/out-network	Covered in/out-network	Covered out-of-network

NATIONAL AND INTERNATIONAL TRAVEL ASSISTANCE

As a participant in Cigna Group Life, you and your immediate family members are automatically covered by Cigna Secure Travel when you travel, whether for business or pleasure.

Pre-Trip Assistance

- Consulate and embassy locations
- Currency exchange information
- Health hazards advice and inoculation requirements
- Passport and visa information
- Weather information
- Hotel and airport locator service

Medical Assistance

- Locating medical care
- Assist in communications with medical providers
- Provide translation and interpreter services 24/7 if you are outside of the United States
- Hotel convalescence arrangements
- Medical insurance coordination for medical care
- Prescription drug assistance to obtain emergency or needed medications

Emergency Transportation Services

Related medical services, medical supplies, and a medical escort are covered where applicable and necessary:

- Repatriation if it is medically necessary after initial treatment and stabilization.
- Family or friend travel arrangements if you are hospitalized for more than 7 days and are traveling alone. Cigna Secure Travel will provide round-trip economy airfare for one family member or friend to the location of your hospital.

- Return of dependent children if you are hospitalized for more than 7 days – to coordinate the return of a dependent back to the United States. Cigna Secure Travel
- will provide one-way economy airfare for children under age 18 to their permanent residence, including an escort for children, if necessary.
- Vehicle return if you require emergency evacuation or repatriation.

Travel Assistance Services

- Emergency credit card and ticket replacement for lost, stolen, or damaged cards or tickets.
- Emergency passport and document replacement for lost, stolen, or damaged passports or travel documentation.
- Emergency cash and payment assistance
- Emergency message service to relay information to family members
- Missing luggage assistance
- Location of legal assistance
- Bail bond services

Personal Security Services

Cigna Secure Travel provides real-time security intelligence in the event you feel you are threatened due to political unrest, social instability, weather conditions, health or environmental hazards.

How to Access Services

Contact Cigna Secure Travel at 1-888-226-4567.

PROTECTION WHEN YOU TRAVEL.

Cigna Secure Travel. For added security when you travel domestically or internationally.

Emergencies can happen while traveling on vacation or company business but help is now only a phone call away with Cigna Secure Travel.

Cigna Secure Travel® is available to customers covered under Cigna's Accidental Death & Dismemberment plan.[1] Our customer service center is available 24 hours a day, 365 days a year. In an emergency, the center can even accept collect calls. All of the program services are available when you travel over 100 miles from home on company business or vacation.

To learn more call
888.226.4567

Emergency medical assistance*

Cigna Secure Travel will pay to arrange:

- Transportation to a hospital or medical facility
- Emergency medical evacuation
- Repatriation of remains
- Referrals to physicians, dentists and medical facilities
- Prescription refill services[2]
- New travel plans for a companion who lost existing arrangements due to delays caused by your emergency
- Travel of a dependent child (under age 16) who is left unattended as a result of your illness or injury
- Round-trip (economy class) transportation for a family member if you're expected to be hospitalized for more than 10 days
- Up to $10,000 cash advance for payment of emergency medical services

GO YOU℠

Cigna.

811361 g 10/12 **Offered by: Life Insurance Company of North America or Cigna Life Insurance Company of New York.**

Cigna Secure Travel

From the U.S. and Canada, call 1.888.226.4567
From other locations, call collect 202.331.7635
By fax: 202.331.1528
By email: Cigna@europassistance-usa.com

Emergency services must be coordinated through Cigna Secure Travel. Services coordinated outside of this program may not be eligible for payment.

Policyholder name: _____

Policy # _____ Group# 57

Help with the unexpected*

In time of emergency, Cigna Secure Travel can provide:

- Emergency cash – advance of up to $1,500[2]
- Emergency changes to travel plans
- Emergency message center
- Assistance with lost or stolen items, including luggage, prescriptions and other personal belongings[2]
- Legal referrals to local attorneys, embassies and consultants
- Translation and interpretation assistance
- 24-hour multilingual assistance
- Advancement of bail[2]

Pre-trip planning*

These services include:

- Immunization requirements
- Visa and passport requirements
- Foreign exchange rates
- Embassy/consular referrals
- Travel/tourist advisories
- Temperature and weather conditions
- Cultural information

Cigna.

* The Cigna Secure Travel program is provided under a contract with Europ Assistance USA, Inc. This summary outlines the highlights of the Cigna Secure Travel program. Complete details, including any limitations and both covered and not-covered services, can be found in the applicable agreement.

1. Secure Travel is available for customers covered under a group or blanket accident insurance policy underwritten by Life Insurance Company of North America or Cigna Life Insurance Company of New York be an acceptable replacement.
2. You are responsible for repaying these funds to Cigna Secure Travel as this program does not cover these expenses.

CIGNA LIFE INSURANCE BENEFITS

Basic Life Insurance and AD&D

You are automatically covered (after 90 days) for one times your annual salary (to a maximum of $100,000) of basic life insurance at no cost to you. In addition, one times your annual salary of Accidental Death and Dismemberment (AD&D) insurance may also be payable if you die in an accident. You are automatically covered in these programs.

Voluntary Life Insurance and AD&D

Voluntary life insurance is available to employees who would like additional life insurance beyond what Hughes Federal Credit Union provides. Your cost is based on your age as of January 1 of each plan year. Your employee voluntary AD&D coverage is the same as the voluntary life amount that you elect. The maximum amount of voluntary life insurance that you can elect through Hughes Federal Credit Union's group plan is five times your annual base salary, or $300,000, in increments of $10,000, whichever is less. Evidence of insurability is required for coverage amounts over $100,000.

When electing or changing voluntary life after the initial offering, you may increase your voluntary life coverage in multiples of $10,000. Evidence of insurability is required for coverage elected after the initial offering. Voluntary life coverage is paid for with after-tax dollars and may be cancelled at any time.

In the event of your death, employee life and AD&D benefits are paid to your designated beneficiary. It is important to keep your beneficiary information current. If you wish to change your beneficiary, contact Human Resources.

Dependent Life Insurance

You may purchase Spouse and Dependent Life Insurance coverage as a separate election from your Voluntary Life Insurance coverage. Please refer to the eligible dependent section on page 7 of this Guide for a definition of eligible spouse and eligible dependent. The maximum amount of voluntary life insurance that you can elect for your spouse is $150,000.00, in increments of $5,000. Evidence of insurability is required for coverage amounts over $25,000. Dependent life insurance is $10,000 for dependents 6 months to 19 years.

If you elect coverage for your dependents, you are automatically the beneficiary for your spouse and children.

You may learn more about the plan by visiting *www.cigna.com*. Select the link 'Click Here if you are an Employee/Insured' to register.

SUPPLEMENTAL LIFE COST

Age	Employee Coverage (Life only)	Employee Coverage (Life + AD&D)
	per $1,000 coverage	per $1,000 coverage
<30	$0.07	$0.09
30-34	$0.07	$0.09
35-39	$0.11	$0.13
40-44	$0.17	$0.19
45-49	$0.29	$0.31
50-54	$0.51	$0.53
55-59	$0.84	$0.86
60-64	$1.13	$1.15
65-69*	$1.75	$1.77
70-74*	$3.08	$3.10
75-99*	$5.03	$5.05
Election Options	Elect in $10,000 increments. Evidence of insurability required after initial new hire enrollment.	Same as voluntary life coverage
Minimum Coverage	$10,000	Same as voluntary life coverage
Maximum Guaranteed Coverage	$100,000	Same as voluntary life coverage
Maximum Coverage	$300,000 **OR** 5x annual salary, whichever is less	Same as voluntary life coverage
Portability/Conversion Option	Portability/Conversion Option	Portability/Conversion Option

* Life and AD&D benefits for employees will terminate at age 99 or upon retirement, whichever occurs first. Prior to this, employee benefits reduce by 35% at age 65, an additional 20% at age 70, and an additional 10% of the original amount at age 80. Life and AD&D benefits for spouse coverage will terminate when the spouse attains age 70. Spouse benefits reduce as the employee's benefits reduced based on the schedule above.

Age	Spouse Coverage (Life only)	Spouse Coverage (Life & AD&D)
	per $1,000 coverage	per $1,000 coverage
<30	$0.07	$0.09
30-34	$0.07	$0.09
35-39	$0.11	$0.13
40-44	$0.17	$0.19
45-49	$0.29	$0.31
50-54	$0.51	$0.53
55-59	$0.84	$0.86
60-64	$1.13	$1.15
65-69*	$1.75	$1.77
Election Options	Elect in $5,000 increments. Evidence of insurability required after initial new hire enrollment.	Elect in $5,000 increments. Evidence of insurability required after initial new hire enrollment.
Minimum Coverage	$5,000	$5,000
Maximum Guaranteed Coverage	$25,000	$25,000
Maximum Coverage	$150,000	$150,000
Portability/Conversion Option	Portability/Conversion Option	Portability/Conversion Option

* Life and AD&D benefits for employees will terminate at age 99 or upon retirement, whichever occurs first. Prior to this, employee benefits reduce by 35% at age 65, an additional 20% at age 70, and an additional 10% of the original amount at age 80. Life and AD&D benefits for spouse coverage will terminate when the spouse attains age 70. Spouse benefits reduce as the employee's benefits reduced based on the schedule above.

Dependent Coverage	Monthly Cost
$10,000.00	$2.00

SHORT-TERM DISABILITY (STD) INSURANCE

As an employee of Hughes Federal Credit Union, you are automatically enrolled in the Cigna STD program, starting on your 91st day of work.

If you become unable to work due to pregnancy or a non-work related injury or illness, you may receive a weekly benefit up to 60% of your weekly base pay, to a maximum of $1,500, for a period up to 13 weeks. The plan has a 14 day elimination period before benefits become payable. There are no pre-existing condition limitations, but you must meet the actively-at-work provision at the time of enrollment; coverage will not become effective until the provision is met.

If you are facing a possible short-term disability, you should contact Human Resources as soon as possible for the information you need to apply for STD benefits.

LONG-TERM DISABILITY (LTD) INSURANCE

As an employee of Hughes Federal Credit Union, you are automatically enrolled in the Cigna LTD program, starting on your 91st day of work.

Your LTD benefits will pay up to 60%, to a maximum of $6,000, of your monthly income during your disability. Your benefits may be subject to an offset based on Social Security payments, retirement benefits and other disability benefits. LTD benefits will end as determined by the plan document provisions. Medical documentation of your disability is required to continue your payment of benefits.

A pre-existing condition exclusion is in effect for the first year if you received treatment in the three months prior to enrollment.

LTD BENEFITS ARE COORDINATED WITH STD BENEFITS.

FLEXIBLE SPENDING ACCOUNTS (FSA)

If you have **not** elected to participate in UnitedHealthcare's HSA Plan, you have the option to participate in a Health Care Flexible Spending Account administered by The Advantage Group. You may also choose to participate in the Dependent Care Flexible Spending Account administered by The Advantage Group, whether or not you are enrolled in UnitedHealthcare's HSA.

- The plan year for FSA is January 1 through December 31.
- Your elections from the prior year do not carry over to the new plan year.
- You must enroll every year.
- Hughes Federal Credit Union Flexible Spending Accounts Open Enrollment is generally held in November of each year. Elections become effective the following January 1.
- You specify the dollar amount of your earnings to be deposited into each account each pay period.
- The amount is deducted from your checks before taxes are taken out, lowering your taxable income and your taxes.
- Throughout the year, after you incur an eligible expense, you submit a claim form and your invoices to The Advantage Group for reimbursement.
- You must file claims for expenses that you incurred during the plan year no later than March 31 following the end of the plan year.
- If your employment terminates or you change to non-benefit eligible status, your "plan year" will end effective with your last day in which the change occurred. Only those expenses which were incurred while employed may be submitted for reimbursement. You must file claims for these expenses within 90 days of your termination date.
- The Advantage Group reimburses you from the money you have set aside in your Flexible Spending Account.
- The Advantage Group offers direct deposit during your initial eligibility or Open Enrollment.
- Contact The Advantage Group at 1-877-506-1660 if you have questions or problems submitting a claim.

Use it or Lose it!

It is important to set aside only as much money in your Flexible Spending Accounts as you intend to use each plan year. IRS regulations require that all money contributed to your Flexible Spending Accounts must be used to pay for expenses incurred (when the services are provided, not when billed or paid) during that plan year only. Otherwise, your money is forfeited. Estimate carefully!

Note: When enrolling for a partial Plan year (from your effective date through December 31) remember to include only reimbursable expenses for that period.

Flexible Spending Accounts Life Events/Mid-Year Changes

You cannot change your elections to your Health Care and/or Dependent Care Flexible Spending Accounts after enrollment unless you have a Qualified Life Event as defined by the IRS that causes you, your spouse, or a dependent to gain or lose coverage. The requested change must correspond with the gain or loss of coverage and must be submitted in writing within 31 days of the event.

Tax Credit

There are additional IRS rules that apply to your Dependent Care Flexible Spending Account contributions. You may be eligible to claim the dependent tax care credit on your Federal income tax return. You may want to consult a tax advisor to determine whether participating in the Dependent Care Flexible Spending Account or taking the dependent care tax credit gives you the greater advantage.

Using Your Flexible Spending Accounts

You have several options for obtaining and filing a claim against your Flexible Spending Account. You may obtain a claim form in the followings ways:

- On the web – You may download a claim form at *www.flexasap.com*.
- On the phone – You may call The Advantage Group at 1-877-506-1660 and request a claim form.

You will need to fill out your claim form and attach copies of invoices for services you received.

MEDICAL AND DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

	Health Care	Dependent Care
Maximum Contributions	$2,600 annually	$5,000 annually ($2,500 if married and filing separately)
Use of the Account	• To pay (with pretax money) for health-related expenses that are not covered or only partially covered by your health plans, including expenses for your spouse or children not enrolled in your medical, dental or vision plans. • To pay for over-the-counter medications that will be used to treat an existing or imminent condition.	• Expenses for care of an eligible dependent, that is inside or outside your home. • Care provided for your children under the age of 13 for whom you have custody, for a physically or mentally handicapped spouse or other dependents who spend at least eight hours a day in your home • Dependent care provided so that you can work
Samples of Eligible Expenses	• Copayments • Deductibles • Charges above reasonable and customary limits • Dental fees • Eyeglasses, exam fees, contact lenses and solution, Lasik surgery • Orthodontia • Nonprescription medications (e.g., cold medicines, allergy medicines, antacids, pain relievers with a prescription)	• Services provided by a day care facility. Must be licensed if the facility cares for six or more children • Babysitting services while you work • Practical nursing care • After school care • Preschool
What's Not Covered	• All insurance premiums • Items not eligible for health care tax exemptions by IRS (e.g., cosmetic surgery) • Long-term care expenses	• Private school tuition including kindergarten • Overnight camp expense • Babysitting when you are not working • Transportation and other separately billed charges • Residential nursing home care
Restrictions/Other information	• See IRS Publication 502 (expenses in this plan qualify based on when the services are provided regardless of when you pay for the expense) or go to The Advantage Group's web site at *www.flexasap.com* for specific details on what expenses are allowed • You cannot transfer money from one account to the other • Your election amount may be increased (but not decreased) if you have a Qualified Life Event	• See IRS Publication 502 (expenses in this plan qualify based on when the services are provided regardless of when you pay for the expense) or go to The Advantage Group's web site at *www.flexasap.com* for specific details on what expenses are allowed • You may not use the account to pay your spouse, your child who is under age 19 or a person whom you could claim as a dependent for tax purposes • You cannot change your election unless you have a Qualified Life Event

COBRA CONTINUATION OF COVERAGE NOTICE

Federal law requires that most group health plans give employees and their families the opportunity to continue their group health coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee (or retired employee) covered under the group health plan and the covered employee's spouse and dependent children enrolled in the group health plan. (Certain newborns, newly adopted children, and alternative recipients under Qualified Medical Child Support Orders QMCSOs may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.)

COBRA coverage is the same coverage that Hughes Federal Credit Union group health insurance plans (collectively, the "Plan") give to other participants or beneficiaries under the Plan who are not receiving COBRA coverage. Each qualified beneficiary who elects COBRA coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including open enrollment and HIPAA special enrollment rights.

COBRA applies only to medical, dental, and vision coverages offered by Hughes Federal Credit Union ("Hughes") and to Flexible Spending Accounts (FSA) offered by Hughes through The Advantage Group and not to any other benefits such as life insurance, disability, or accidental death and dismemberment. The Plan provides no greater COBRA rights than what COBRA requires.

Electing Coverage

To elect COBRA medical, dental, or vision coverage, you must complete the Election Form according to the directions on the Election Form and mail or deliver by the date specified to Human Resources. Each qualified beneficiary has a separate right to elect COBRA coverage. For example, the employee's spouse may elect COBRA coverage even if the employee does not. COBRA coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect COBRA coverage on behalf of any dependent children. The employee or the employee's spouse can elect COBRA coverage on behalf of all of the qualified beneficiaries.

You may elect COBRA under the group health coverages (medical, dental, vision and health care FSA) in which you were covered under the Plan on the day before the qualifying event. Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health plan coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a qualified beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under another group health plan (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

Electing Health Care Flexible Spending

COBRA coverage under the Health Care FSA will be offered only to qualified beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if the annual limit elected under the Health Care FSA by the covered employee, reduced by reimbursements

of expenses incurred up to the time of the qualifying event, is equal to or more than the amount of premiums for Health Care FSA COBRA coverage that will be charged for the remainder of the plan year. COBRA coverage for the Health Care FSA, if elected, will consist of the Health Care FSA coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by expenses reimbursed up to the time of the qualifying event). The use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the plan year, and COBRA coverage will terminate at the end of the plan year. All qualified beneficiaries who were covered under the Health Care FSA will be covered together for Health Care FSA COBRA coverage. However, each qualified beneficiary has separate election rights, and each could alternatively elect separate COBRA coverage to cover that qualified beneficiary only, with a separate Health Care FSA annual coverage limit and a separate COBRA premium. If you are interested in this alternative, contact Human Resources.

Special Considerations

In considering whether to elect COBRA coverage, you should take into account that a failure to elect COBRA will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of COBRA coverage may help you not have such a gap. Second, you may lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get COBRA coverage for the maximum time available to you. Finally, you should take into account that you may have special enrollment rights under federal law. You may have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage under the Plan ends because of the Qualifying Life Event listed above. You will also have the same special enrollment right at the end of COBRA coverage if you get COBRA coverage for the maximum time available to you.

COBRA Duration

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued only for up to a total of 18 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries (other than the employee) who lose coverage under the Plan as a result of the qualifying event can last up to 36 months from the date of Medicare entitlement. This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months before the termination of employment or reduction of hours.

In the case of a loss of coverage due to an employee's death, divorce or legal separation, or a dependent child ceasing to be a dependent under the terms of the Plan, COBRA coverage may be continued for up to a total of 36 months.

Regardless of the qualifying event, health care FSA COBRA coverage may only be continued to the end of the plan year in which the qualifying event occurred and cannot be extended for any reason.

This notice shows the maximum period of COBRA coverage available to qualified beneficiaries.

COBRA coverage will automatically terminate before the end of the maximum period if:

- A required premium is not paid-in-full on time,
- A qualified beneficiary becomes covered, after electing COBRA coverage under another group health plan (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied),
- A qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA coverage,
- Hughes ceases to provide any group health plan for its employees; or
- During a disability extension period (the disability extension is explained below), the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled.

COBRA coverage may also be terminated for any reason (for example, the Plan would terminate coverage of a participant or beneficiary not receiving COBRA coverage as in a case of fraud). You must notify the applicable carrier(s) in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare (Part A, Part B or both) or becomes covered under other group health plan coverage (but only after any preexisting condition exclusions of that other plan for a preexisting condition of the qualified beneficiary have been exhausted or satisfied). COBRA coverage will terminate (retroactively if applicable) as of the date of Medicare entitlement or as of the beginning date of the other group health coverage (after exhaustion or satisfaction of any applicable preexisting condition exclusion). The claims administrators, insurance carriers and/or HMOs may require repayment of all benefits paid after the termination date, regardless of whether or when you provide notice of Medicare entitlement or other group health plan coverage.

Extension of COBRA Period

If you elect COBRA coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is or becomes disabled or a second qualifying event occurs. You must notify the applicable carriers in writing of a disability or a second qualifying event in order to extend the period of COBRA coverage. Failure to provide notice of a disability or second qualifying event will affect the right to extend the period of COBRA coverage. (The period of COBRA for a Flexible Spending Account cannot be extended beyond the end of the current Plan year under any circumstances).

Disability

If any of the qualified beneficiaries is determined by the Social Security Administration to be disabled, the maximum COBRA coverage period that results from the covered employee's termination of employment or reduction of hours (generally 18 months as described above) may be extended up to a total of 29 months. The disability must have started at some time before the 61st day of COBRA coverage obtained due to the covered employee's termination of employment or reduction of hours with the State and must last until the end of the 18-month period of COBRA coverage. Each qualified beneficiary who has elected COBRA coverage will be entitled to the disability extension if one of them is qualified. The disability extension is available only if you notify the applicable carrier(s) (see "For

More Information" section on page 36) in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

- The date of the Social Security Administration's disability determination
- The date of the covered employee's termination of employment or reduction of hours, or
- The date of which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination or reduction of hours

You must also provide this notice within the original 18 months of COBRA coverage obtained due to the covered employee's termination of employment or reduction of hours in order to be entitled to a disability extension. The notice must be provided in writing and must include the following information:

- The name(s) and address(es) of all qualified beneficiaries who are receiving COBRA due to the initial qualifying event
- The name and address of the disabled qualified beneficiary
- The date that the qualified beneficiary became disabled
- The date that the Social Security Administration made its determination of disability
- A statement as to whether or not the Social Security Administration has subsequently determined that the qualified beneficiary is no longer disabled, and
- The signature, name and contract information of the individual sending the notice

Your notice must include a copy of the Social Security Administration's determination of disability. You must mail this notice within the required time periods to Human Resources (see "For More Information" on page 36).

If the above procedures are not followed or if the notice is not provided within the 60-day notice period, there will be no disability extension of COBRA coverage. If the qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify the applicable carrier(s) of that fact within 30 days after the Social Security Administration's determination. COBRA coverage will end no earlier than the first of the month that begins more than 30 days after the Social Security Administration's determination. COBRA coverage will end no earlier than the first of the month that begins more than 30 days after the date of the final determination by the Social Security Administration that the qualified beneficiary is no longer disabled. The notice must be provided in the same manner as, and include the same information required for, a notice of disability as described above.

Second Qualifying Event

An extension of coverage will be available to spouses and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the first 18 months (or, in the case of a disability extension, the first 29 months) of COBRA coverage following the covered employee's termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a second qualifying event occurs is 36 months from the date COBRA coverage began. Such second qualifying events may include the death of a covered employee, divorce or legal separation

from the covered employee, or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan.

This extension due to a second qualifying event is available only if you notify the applicable carrier(s) (see "For More Information" section on page 36) in writing of the second qualifying event within 60 days after the date of the second qualifying event. The notice must include the following information:

- Name(s) and address(es) of all qualified beneficiaries who are receiving COBRA due to the initial qualifying event
- Nature of the second qualifying event
- Date of the second qualifying event
- Signature, name and contact information of the individual sending the notice

In addition, you must provide documentation supporting the occurrence of the second qualifying event, if Human Resources requests it. Acceptable documentation includes a copy of the divorce decree, death certificate, or dependent child(ren)'s birth certificates, driver's license, marriage license or letter from a university or institution indicating a change in student status.

You must mail this notice within the required time periods to Human Resources.

If the above procedures are not followed or if the notice is not provided within the 60-day notice period, there will be no extension of COBRA coverage due to a second qualifying event.

COBRA Cost

Generally, each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of COBRA coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA coverage.

When and How To Pay for Coverage

If you elect COBRA coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for COBRA coverage no later than 45 days after the date of your election. (This is the date the Election Form is post-marked, if mailed, or the date your Election Form is received by the individual at the address specified for delivery on the Election Form, if hand delivered.) If you do not make your first payment for COBRA coverage in full within 45 days after the date of your election, you will lose all COBRA rights under the Plan.

Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make your first payment. You are responsible for making sure that the amount of your first payment is correct.

After you make your first payment for COBRA coverage, you will be required to make monthly payments for each subsequent month of COBRA coverage. Under the Plan, each of these monthly payments for COBRA coverage is due on the first day of the month for that month's COBRA coverage. If you make a monthly payment on or before the first day of the month to which it applies, your COBRA coverage under the Plan will continue for that month without any break. The Plan will send periodic notices of payments due for these coverage periods - that is, you will receive a bill for your COBRA coverage – it is your responsibility to pay your COBRA premiums on time. If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage under the Plan.

Although monthly payments are due on the first day of each month of COBRA coverage, you will be given a grace period of 30 days after the first day of the month to make each payment for that month. Your COBRA coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. However, if you pay a monthly payment later than the first day of the month to which it applies, but before the end of the grace period for the month, your coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

Your payment should be mailed to:
Hughes Federal Credit Union, P.O. Box 11900, Tucson, AZ 85734-1900

If mailed, your payment is considered to have been made on the date that it is postmarked. If hand delivered, your payment is considered to have been made when it is received. You will not be considered to have made any payment if your check is returned due to insufficient funds or otherwise.

More information about individuals who may be qualified beneficiaries

A child born to, adopted by, or placed for adoption with a covered employee during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected COBRA coverage for himself or herself and enrolls the child within 30 days of the birth, adoption or placement for adoption. To be enrolled in the Plan, the child must satisfy the otherwise applicable eligibility requirements (for example, regarding age).

A child of the covered employee who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by Hughes during the covered employee's period of employment is entitled to the same rights to elect COBRA as any other eligible dependent child of the covered employee.

For More Information

This notice does not fully describe COBRA coverage or other rights under the Plan. More information about COBRA coverage and your rights under the Plan is available from your Human Resources Office.

Address Changes
In order to protect you and your family's rights, it is important that you keep your Human Resources Office informed of any changes in your address and the addresses of family members.

ADDITIONAL BENEFITS

This information regarding additional benefits is an overview of benefits provided by Hughes Federal Credit Union

Supplemental Retirement Savings
Tax Sheltered Annuity IRS Tax Code 401(k)
This type of plan offers the opportunity for you to defer tax on a portion of earnings by purchasing traditional annuity or mutual fund products through Hughes Federal Credit Union's approved vendor(s).

Leave Policies
Bereavement Leave
You are allowed up to three days of leave for bereavement and funeral purposes of covered family members up to twice each year. You may use paid time off upon the death of family members not covered under the bereavement policy.

Family and Medical Leave (FML)
FML provides for up to 12 work weeks of leave during a designated "leave year" for a qualifying reason. You must have at least 12 months of cumulative service and have worked at least 1,250 hours at Hughes during the 12-month period preceding the date FML is to begin.

FML may apply to continuous, intermittent, or reduced schedule absences. The leave requires the use of accrued Paid Time Off (PTO), and all additional FML is unpaid.

FML qualifying reasons:

- The birth and care of a child;
- The adoption or foster care of a child;
- The care of your spouse, child or parent who has a serious health condition;
- Your own serious health condition that prevents you from performing the essential functions of your position.
- Eligible employees are entitled to up to 12 weeks of leave because of "any qualifying exigency" arising out of the fact that the spouse, son, daughter, or parent of the employee is on active duty, or has been notified of an impending call to active duty status, in support of a contingency operation. By the terms of the statute, this provision requires the Secretary of Labor to issue regulations defining "any qualifying exigency." In the interim, employers are encouraged to provide this type of leave to qualifying employees.

- An eligible employee who is the spouse, son, daughter, parent, or next of kin of a covered servicemember who is recovering from a serious illness or injury sustained in the line of duty on active duty is entitled to up to 26 weeks of leave in a single 12-month period to care for the servicemember. This provision became effective immediately upon enactment. This military caregiver leave is available during "a single 12-month period" during which an eligible employee is entitled to a combined total of 26 weeks of all types of FMLA leave.

Holiday Pay
Regular full-time employees shall be granted time off from work with pay for each holiday designated by Hughes. Twelve holidays are granted each year. Generally 1½ Floating Holidays are earned each year, but will vary depending upon the Federal Reserve holiday schedule.

Jury Duty
Employees called upon for service on a jury or as a subpoenaed witness, other than as a plaintiff or defendant, in a judicial or administrative proceeding, shall be granted leave with pay to perform such service. This is limited to a maximum of 20 days over a two-year period.

Military Leave
Employees who are members of the National Guard or a reserve component of the U. S. Armed Forces shall be granted leave without pay, for active duty or active duty training for a period not to exceed 30 work days in any two consecutive calendar years. However, employees may use any available paid time off for the absence.

Employees who are voluntarily or involuntarily placed on extended active duty with the National Guard or the U.S. Armed Forces shall be placed on a leave without pay status in a manner consistent with applicable Arizona Revised Statutes and the Federal Veterans Reemployment Act. Extended active duty is defined as a period of more than 30 calendar days.

Paid Time Off (PTO)
The annual accrual rate for regular full-time employees is:
Years 1 - 5 - 120.12 hours per year
Years 6 – 10 - 159.90 hours per year
Years 11 - 15 - 176.02 hours per year
16 years and beyond - 199.94 hours per year
PTO hours are accrued on a pay period basis.

Unpaid Leaves
Unpaid leaves of up to 45 calendar days may be granted by the responsible manager or VP.

Educational Assistance
Hughes Federal Credit Union provides an educational assistance program that enables employees to continue their education with financial assistance from Hughes. The assistance may be used for spring, fall, winter or summer sessions.

Workers' Compensation

All employees are insured and are provided benefits under the Workers' Compensation Act in the event of a job-related injury or illness. Benefits include medical expenses, compensation for lost work time, permanent disability benefits and death benefits as applicable.

Absence from work due to an on-the-job injury or illness is considered to be a serious health condition for the purposes of applying Family and Medical Leave. If you are eligible for and entitled to FML, the time away from work while you are covered under Workers' Compensation will be credited to your FML entitlement.

GLOSSARY OF TERMS

Actively at Work
The plan provision that requires you to be performing the duties of your occupation in order for coverage to commence. If you are absent due to illness or injury, the coverage doesn't commence until you return to active work status. You are considered actively at work on a paid vacation day or established holiday if you were actively at work on the preceding scheduled work day.

Coinsurance
The division of the allowed amount to be paid on a claim, i.e. 80/20 means 80% is to be paid by insurance and 20% is paid by you.

Coordination of Benefits
A process used to determine payment of a claim when you are covered under more than one group plan. Benefits under the plans are limited to no more than 100 percent of the claim.

Co-payment
The established fee that must be paid to a provider at the time services are rendered.

Deductible
The initial amount on a plan you must pay out of pocket before benefits are paid by your insurance.

Emergency
Defined by each plan in the Plan Description.

In-Network
Services performed by a provider contracted with a network in accordance with all plan requirements.

Indemnity Plan
A health care plan that allows you to choose any licensed provider to receive care. Members are reimbursed for eligible reasonable and customary health care expenses according to the benefits schedule which includes a deductible and coinsurance.

Medically Necessary
Services or supplies provided to identify or treat an illness or injury. Services and supplies must be given in accordance with proper medical practice prevailing in the medical specialty or field at the time the patient received the service or in the least costly setting required for the patient's condition. The service must be consistent with the patient's illness, injury or condition and be required for reasons other than the patient's convenience. The fact that a physician prescribes a service or supply does not necessarily mean it is medically necessary.

Out-of-Network
Services performed by a provider that is not contracted with a network.

Plan Year
January 1 through December 31 for medical, dental, vision plans and Flexible Spending Account plans.

Pre-Existing Condition
A condition diagnosed and/or treated prior to the effective date of coverage or one for which a prudent person would have been treated.

Preferred Provider Organization (PPO)
A plan that allows a member to choose either a provider of their choice or a provider contracted with the network. Choosing an in-network provider will result in a higher percentage of the cost of services being covered.

Premium
The amount you and your employer pay for insurance coverage.

Prescription Drugs
Any drug or medication that requires a physician's order.

Generic Drug
A generic drug is one approved by the U.S. Food and Drug Administration (FDA) that is chemically identical to its brand-name equivalent. To win FDA approval, the generic drug must contain the same amounts of the same active ingredients as its brand-name equivalent. A generic drug typically is less expensive and is sold under a generic name for that drug (usually its chemical name). Because generic drugs are less expensive than their brand-name equivalent, your co-payment usually is less, as well.

Preferred (Formulary) Drug
All preferred brand drugs have received FDA approval as safe and effective, and have been chosen by a committee of physicians and pharmacists.

Non-Preferred (Non-Formulary) Drug
A medication that does not appear on the preferred or generic drug list and carries a higher co-payment.

Reasonable and Customary Charges
The prevailing charge made by physicians, dentists, or other service providers for a similar procedure in a particular geographic area.